

NAME OF SCHOOL _____

FORM AM4

**Record of medicine administered
to an individual child**

Surname	
Forename (s)	
Date of Birth	___ / ___ / ___ M <input type="checkbox"/> F <input type="checkbox"/>
Class	
Condition or illness	
Date medicine provided by parent	
Name and strength of medicine	
Quantity received	
Expiry date	___ / ___ / ___
Quantity returned	
Dose and frequency of medicine	

Checked by:

Staff signature _____ **Signature of parent** _____

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

FORM AM4 (Continued)

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

